

## Wade-Taxter, Megan (ISDH)

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**From:** Becker, Angela  
**Sent:** Wednesday, September 19, 2018 2:34 PM  
**To:** Wade-Taxter, Megan (ISDH)  
**Subject:** FW: public records request 07 27 2018  
**Attachments:** 20180824135353295.pdf

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**From:** Becker, Angela  
**Sent:** Friday, August 24, 2018 2:44 PM  
**To:** Humbarger, Cathie <Cathie.Humbarger@Ichooselife.org>  
**Subject:** public records request 07 27 2018

Good afternoon Ms. Humbarger.

The Indiana State Department of Health has attached copies of all available and producible records responsive to your request dated July 27, 2018. We are able to produce this response more quickly because it did not require heavy legal review. You seek:

1. Abortion facility license applications for new abortion facilities from May 1, 2018 – July 27, 2018.
2. Copies of licenses for all existing abortion facilities for licensure period July 1, 2018 – June 30, 2019.
3. Hospital admitting privileges or doctor relationships documentation for licensure period July 1, 2018 – June 30, 2019.
4. Notification documentation to hospitals in the counties and contiguous counties where abortionists operate of hospital admitting privileges/back up relationship physician for licensure period July 1, 2018 – June 30, 2019.
5. Any documents mentioning Whole Woman's Health, received from Whole Woman's Health or concerning the application for an abortion facility license for Whole Woman's Health including any amended applications or appeals from May 1, 2018 through July 27, 2018.

Very Sincerely,

**ANGELA L. BECKER**  
*Litigation Liaison & Public Records Coordinator*  
Office of Legal Affairs  
Indiana State Department of Health  
317.232.3119 office  
317.234.6278 fax  
[abecker2@isdh.in.gov](mailto:abecker2@isdh.in.gov)  
[www.StateHealth.in.gov](http://www.StateHealth.in.gov)





July 27, 2018

Hilari Sautbine  
Vital Records  
Indiana State Department of Health  
2 North Meridian Street  
Indianapolis, IN 46204

Dear Ms. Sautbine,

Pursuant to the provisions of governing law, including but not limited to, I.C. §§ 5-14-3-1 and 3, I am requesting copies of the following:

1. Abortion facility license applications for new abortion facilities from May 1, 2018 – July 27, 2018.
2. Copies of licenses for all existing abortion facilities for licensure period July 1, 2018 – June 30, 2019.
3. Hospital admitting privileges or doctor relationships documentation for licensure period July 1, 2018 – June 30, 2019.
4. Notification documentation to hospitals in the counties and contiguous counties where abortionists operate of hospital admitting privileges/back up relationship physician for licensure period July 1, 2018 – June 30, 2019.
5. Any documents mentioning Whole Woman's Health, received from Whole Woman's Health or concerning the application for an abortion facility license for Whole Woman's Health including any amended applications or appeals from May 1, 2018 through July 27, 2018.

Please send to the address below or e-mail to [cathie.humbarger@ichooselife.org](mailto:cathie.humbarger@ichooselife.org).

Please let me know of any cost related to this request and I will remit payment immediately.

Mail to:  
Cathie Humbarger, VP  
Indiana Right to Life  
2126 Inwood Drive  
Fort Wayne, IN 46815

Sincerely,

A handwritten signature in cursive script that reads "Cathie Humbarger".

CLINIC FOR WOMEN  
3607 W 16<sup>TH</sup> STREET, SUITE 2B  
INDIANAPOLIS, INDIANA

Indiana State  
Department of Health  
*An Equal Opportunity Employer*

Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 5, 2018

Facility 011133

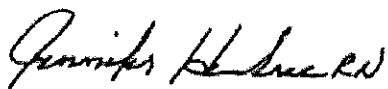
LADONNA PRINCE, MANAGER  
CLINIC FOR WOMEN  
3607 W 16TH ST STE 2B  
INDIANAPOLIS, IN 46222

Dear LADONNA PRINCE, MANAGER:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2018 through June 30, 2019.

Sincerely,



JENNIFER HEMBREE RN  
Nurse Surveyor Supervisor  
Program Director Hospitals/ASCs  
317/232-3095

Enclosure (1)



Indiana  
A State that Works

2 North Meridian Street Indianapolis, IN 46204  
317.233.1325  
[www.statehealth.in.gov](http://www.statehealth.in.gov)

To promote, protect, and  
improve the health and safety  
of all Hoosiers.

# Indiana State Department of Health

## Abortion Clinic License

*This is to certify that:*

Counseling of Indiana Inc. d/b/a  
**CLINIC FOR WOMEN**  
3607 W 16TH ST STE 2B  
INDIANAPOLIS, IN

*an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.*

*This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.*

*License number 18-0111133-1 is effective July 1, 2018 and expires June 30, 2019.*



*Randall Snyder*

RANDALL SNYDER PT, MBA  
DIRECTOR, ACUTE CARE DIVISION

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

RECEIVED  
JUL 02 2018

DATE 14-JUN-18

RECEIPT NO. 1835821

DIVISION ACUTE CARE (AC)

FROM CLINIC FOR WOMEN

STREET 3607 W B16TH STREET STE B2

CITY INDPLS

STATE IN

46222

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 1,000.00  
Account: 423010, Department: 195129)

AMOUNT	\$	1,000.00	CASH
CHECKS AND MONEY ORDERS	9123420747:	\$500.00;	9123420748: \$500.00

REFUND

MAIL CLERK  
Ford, Willia

REMARKS

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

DATE 14-JUN-18

RECEIPT NO. 1835821

DIVISION ACUTE CARE (AC)

FROM CLINIC FOR WOMEN

STREET 3607 W BL6TH STREET STE B2

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LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 1,000.00  
Account: 423010, Department: 195129)

AMOUNT \$ 1,000.00

CASH

CHECKS AND  
MONEY ORDERS

9123420747:

\$500.00; 9123420748:

\$500.00

REFUND

MAIL CLERK  
Ford, Willia

REMARKS



**APPLICATION FOR LICENSE  
TO OPERATE AN ABORTION CLINIC**

State Form 52233 (R3 / 3-14)  
Approved by State Board of Accounts, 2014  
Indiana State Department of Health-Division of Acute Care  
(Pursuant to IC 16-21-2 and 410 IAC 26)

1835821  
**RECEIVED**  
JUL 02 2018

**Division of Acute Care Use Only**

Date Received (mm/dd/yyyy) \_\_\_\_\_ Date Approved (mm/dd/yyyy) \_\_\_\_\_ Date Rejected (mm/dd/yyyy) \_\_\_\_\_

Please Type or Print Legibly.

**SECTION I - TYPE OF APPLICATION**

Application (Check appropriate item.)

☐ New Facility

☒ Renewal

☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) \_\_\_\_\_  
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

**SECTION II - IDENTIFYING INFORMATION**

**A. Abortion Clinic Location**

Name of Abortion Clinic

Clinic For Women

Street Address (number and street)

36007 West 16<sup>th</sup> Street Suite B2

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46222

Telephone Number

(317)

Fax Number

(317)

955.2641 955.2687

Abortion Clinic e-mail address: CFW@clinic4women.net

Internet Web Address: WWW.clinic4women.net

**B. Mailing Address (if different from abortion clinic location)**

Street Address (number and street)

P.O. Box

City

County

ZIP Code +4

**C. Licensee/Ownership Information**

Licensee: The applicant entity as registered with the secretary of state

Counseling of Indiana Inc.

Street Address (number and street)

36007 West 16<sup>th</sup> Street

P.O. Box

City

Indianapolis

State

Indiana

ZIP Code+4

46222

Telephone Number

(317) 955.2641

Fax Number

(317) 955.2687

EIN Number

351391714

Fiscal Year End Date (mm/dd)

12.31

RECEIVED  
JUL 02 2018



**APPLICATION FOR LICENSE  
TO OPERATE AN ABORTION CLINIC**

State Form 52233 (R3 / 3-14)  
Approved by State Board of Accounts, 2014  
Indiana State Department of Health-Division of Acute Care  
(Pursuant to IC 16-21-2 and 410 IAC 26)

Division of Acute Care Use Only

Date Received (mm/dd/yyyy) \_\_\_\_\_ Date Approved (mm/dd/yyyy) \_\_\_\_\_ Date Rejected (mm/dd/yyyy) \_\_\_\_\_

Please Type or Print Legibly.

**SECTION I - TYPE OF APPLICATION**

Application (Check appropriate item.)

☐ New Facility ☒ Renewal

☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) \_\_\_\_\_  
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

**SECTION II - IDENTIFYING INFORMATION**

**A. Abortion Clinic Location**

Name of Abortion Clinic

Clinic For Women

Street Address (number and street)

36007 West 16th Street Suite B2

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46222

Telephone Number

(317)

Fax Number

(317)

955-2641 955-2687

Abortion Clinic e-mail address: CFW@clinic4women.net

Internet Web Address: WWW.clinic4women.net

**B. Mailing Address (if different from abortion clinic location)**

Street Address (number and street)

P.O. Box

City

County

ZIP Code +4

**C. Licensee/Ownership Information**

Licensee: The applicant entity as registered with the secretary of state

Counseling of Indiana Inc.

Street Address (number and street)

36007 West 16th Street

P.O. Box

City

Indianapolis

State

Indiana

ZIP Code+4

46222

Telephone Number

(317) 955-2641

Fax Number

(317) 955-2687

EIN Number

351391714

Fiscal Year End Date (mm/dd)

12-31

**D. Services provided under this license:**

Code items 1 and 2 as follows: 1. Provided directly by employee(s), 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: ☒ Laboratory: CLIA Certificate Number 15D0894576 ☐ Radiology ☐ Counseling

☐ Family Planning ☐ Pharmacy ☐ Other (List): \_\_\_\_\_

2. Surgical Services: ☐ Gynecology ☒ Other (List): Abortion Services

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing: Physicians: ☒ Registered Nurses: ☒ Licensed Practical Nurses: ☒ 1 Receptionist  
4 Surg Techs  
3 Medical Asst.  
2 Lab Techs  
2 Patient Educators  
2 Specimen Techs  
1 Nurse Practitioner  
 Licensed Social Workers: ☐ Other (List title and number): \_\_\_\_\_

**E. Number of Procedure Rooms Utilizing:**

Local analgesia/anesthetic ☒ Moderate/Conscious Sedation ☐

**F. Type of Entity:**

For Profit

- ☐ Individual  
☐ Partnership  
☒ Corporation  
☐ Limited Liability Company  
☐ Sole Proprietorship  
☐ Other (specify) \_\_\_\_\_

Non-Profit

- ☐ Church Related  
☐ Individual  
☐ Partnership  
☐ Corporation  
☐ Limited Liability Company  
☐ Other (specify) \_\_\_\_\_

Government

- ☐ State  
☐ County  
☐ City  
☐ City/County  
☐ Hospital District  
☐ Federal  
☐ Other (specify) \_\_\_\_\_

**G. Officers (if the business entity is incorporated)**

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	LaDonna Prince	
Vice-President/Vice-Chairperson/COO	Sally Borne	
Treasurer/CFO	Melissa Baker	
Secretary	Rita Jones	

**H. Ownership and/or Change in Ownership:**

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (Use additional sheet if necessary.)

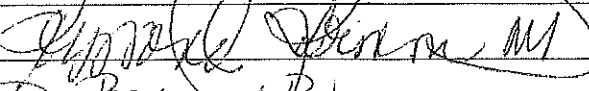
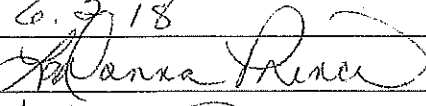
Name	Business Address/City/State/ZIP	EIN Number
LaDonna Prince	3107 W. 10 <sup>th</sup> Street Indianapolis, IN 46222	351391716
Dennis Nickle	3107 W 16 <sup>th</sup> St. Indianapolis, IN 46222	351391716

**CERTIFICATION OF APPLICATION**

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Dr. Raymond Robinson
Date of Signature (mm/dd/yyyy):	6.2.18
Signature of the Clinic Administrator:	
Printed Name and Title:	LaDonna Prince
Date of Signature (mm/dd/yyyy):	6.2.2018

**See the following page for instructions regarding licensure fees and submission of this application.**

### License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
<input type="checkbox"/>	Zero to 799	\$500.00
<input checked="" type="checkbox"/>	800 to 3,499	\$1,000.00
<input type="checkbox"/>	3,500 to 6,999	\$2,000.00
<input type="checkbox"/>	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

*Enclose the following:*

- 1. A completed Application for License to Operate an Abortion Clinic (this form).*
- 2. Any supporting attachments.*
- 3. For each physician performing procedures, either:*
  - (A) A copy (in writing) of the physician's admitting privileges; or*
  - (B) A copy of:*
    - (1) his/her written agreement with another physician with admitting privileges; and*
    - (2) a copy (in writing) of that physician's admitting privileges.*
- 4. Payment made payable to "Indiana State Department of Health."*

*Mail to:*

INDIANA STATE DEPARTMENT OF HEALTH  
CASHIER'S OFFICE  
P. O. BOX 7236  
INDIANAPOLIS, INDIANA 46207-7236

RECEIVED  
SEP 11 2017

Physicians of Clinic For Women  
3607 West 16<sup>th</sup> Street Ste B2  
Indianapolis, IN 46222

RE: Backup Agreement

Dear . , M.D., M.D., , M.D. and  
M.D.:

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation or other medical need that requires hospitalization.

I have staff privileges in Obstetrics and Gynecology at  
in Indianapolis. I, or one of my partners, will arrange patient admission and care for each patient needing my services according to each patient's need.

In the event my services are needed under this agreement, contact me by calling my office at  
In addition, I will provide you with my cell phone and pager numbers. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) day notice if I need to modify or cancel this agreement for any reason.

M.D.

September 11, 2017

July 05, 2018

Randall D Snyder  
Division Director, Acute Care  
Indiana State Department of Health

RE: . MD

Dear Sir/Madam:

committed to the provision of quality care and are accredited by The Joint Commission and/or Healthcare Facilities Accreditation Program. Our Ambulatory Surgery Centers are accredited by the Accreditation Association for Ambulatory Health Care. We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Facility:

Staff Appointment Date: From: - Present

Staff Status:

Department/Section:

Specialty:

If you need additional information, please contact me.

Sincerely,

June 11, 2018

Clinic for Women  
3607 West 16<sup>th</sup> Street, Suite B-2  
Indianapolis, IN 46222

To Whom It May Concern:

This letter is to verify that  
She was appointed to the Medical Staff of

M.D. was granted temporary privileges on August  
on October

Dr. is an Active member of our Department and has admitting privileges. meets the  
necessary requirements to maintain membership and clinical privileges on the Medical Staff.

If you need any further information, please contact me at

Sincerely,

Director  
Medical Staff Affairs

*Received by email from  
Medical Affairs Director  
RB-1-*

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY

421 S. COLLEGE AVENUE

BLOOMINGTON, INDIANA

Indiana State  
Department of Health  
*An Equal Opportunity Employer*

Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

May 31, 2018

Facility 011117

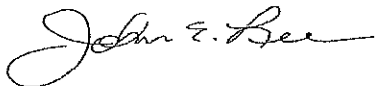
LAURA MILLER, MANAGER  
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC  
200 S. MERIDIAN STREET, SUITE 400  
INDIANAPOLIS, IN 46225

Dear LAURA MILLER, MANAGER:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2018 through June 30, 2019.

Sincerely,



JOHN LEE, RN, MBA  
DEPUTY DIRECTOR OF ACUTE CARE  
ACUTE CARE DIVISION  
317/233-7487

Enclosure (1)

# Indiana State Department of Health

## Abortion Clinic License

*This is to certify that:*

Planned Parenthood Of Indiana and Kentucky INC d/b/a  
**PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC**  
421 S COLLEGE AVE  
BLOOMINGTON, IN

*an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.*

*This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.*

*License number 18-011117-1 is effective July 1, 2018 and expires June 30, 2019.*



*Randall Snyder*

RANDALL SNYDER PT, MBA  
DIRECTOR, ACUTE CARE DIVISION

RECEIVED  
MAY 30 2018

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

DATE 29-MAY-18

RECEIPT NO. 1834334

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 1,000.00  
Account: 423010, Department: 195129)

AMOUNT	\$	1,000.00	CASH
CHECKS AND MONEY ORDERS	66938:	\$1,000.00	

REFUND

MAIL CLERK  
Ford, Willia

REMARKS BLOOMINGTON IN

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

DATE 29-MAY-18

RECEIPT NO. 1834334

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 1,000.00  
Account: 423010, Department: 195129)

AMOUNT \$ 1,000.00

CASH

CHECKS AND 66938: \$1,000.00  
MONEY ORDERS

REFUND

MAIL CLERK  
Ford, Willia

REMARKS BLOOMINGTON IN

RECEIVED  
MAY 30 2018



**APPLICATION FOR LICENSE  
TO OPERATE AN ABORTION CLINIC**

State Form 52233 (R3 / 3-14)  
Approved by State Board of Accounts, 2014  
Indiana State Department of Health-Division of Acute Care  
(Pursuant to IC 16-21-2 and 410 IAC 26)

**Division of Acute Care Use Only**

Date Received (mm/dd/yyyy) \_\_\_\_\_ Date Approved (mm/dd/yyyy) \_\_\_\_\_ Date Rejected (mm/dd/yyyy) \_\_\_\_\_

Please Type or Print Legibly.

**SECTION I - TYPE OF APPLICATION**

Application (Check appropriate item.)

☐ New Facility ☒ Renewal ☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) \_\_\_\_\_  
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

**SECTION II - IDENTIFYING INFORMATION**

**A. Abortion Clinic Location**

Name of Abortion Clinic

Planned Parenthood of Indiana and Kentucky - Bloomington

Street Address (number and street)

421 S. College

P.O. Box

City

Bloomington

County

Monroe

ZIP Code +4

47403

Telephone Number

( 812 )

336-0219

Fax Number

( 812 )

336-2401

Abortion Clinic e-mail address: laura.miller@ppink.org

Internet Web Address: www.ppink.org

**B. Mailing Address (if different from abortion clinic location)**

Street Address (number and street)

200 S. Meridian Street, Suite 400

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46225

**C. Licensee/Ownership Information**

Licensee: The applicant entity as registered with the secretary of state

Planned Parenthood of Indiana and Kentucky, INC.

Street Address (number and street)

200 S. Meridian Suite 400

P.O. Box

City

Indianapolis

State

Indiana

ZIP Code+4

46225

Telephone Number

( 317 ) 637-4343

Fax Number

( 317 ) 637-4344

EIN Number

35-0874276

Fiscal Year End Date (mm/dd)

06/30

**D. Services provided under this license:**

Code items 1 and 2 as follows: 1. Provided directly by employee(s). 2. Provided by a contract service. 3. Both 1 and 2.

1. Ancillary Services: ☒ Laboratory: CLIA Certificate Number 1500360690 ☐ Radiology ☐ Counseling

☒ Family Planning ☐ Pharmacy ☐ Other (List): \_\_\_\_\_

2. Surgical Services: ☒ Gynecology ☐ Other (List): \_\_\_\_\_

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: ☒ Registered Nurses: ☒ Licensed Practical Nurses: ☒

Licensed Social Workers: ☒ Other (List title and number): 1 APRN 1 Nurse Center Manager 1 Health Center Assistant

**E. Number of Procedure Rooms Utilizing:**

Local analgesia/anesthetic ☒

Moderate/Conscious Sedation ☒

**F. Type of Entity:**

For Profit

- ☐ Individual  
☐ Partnership  
☐ Corporation  
☐ Limited Liability Company  
☐ Sole Proprietorship  
☐ Other (specify) \_\_\_\_\_

Non-Profit

- ☐ Church Related  
☐ Individual  
☐ Partnership  
☒ Corporation  
☐ Limited Liability Company  
☐ Other (specify) \_\_\_\_\_

Government

- ☐ State  
☐ County  
☐ City  
☐ City/County  
☐ Hospital District  
☐ Federal  
☐ Other (specify) \_\_\_\_\_

**G. Officers (if the business entity is incorporated)**

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Kim Green	200 S. Meridian St. Suite 400
Vice-President/Vice-Chairperson/COO	Michael Carter	Indianapolis, IN 46225
Treasurer/CFO	Nathan Ringham	
Secretary	Christie Moore	

**H. Ownership and/or Change in Ownership:**

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (Use additional sheet if necessary.)

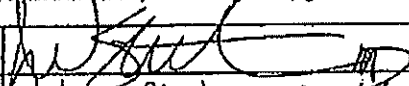
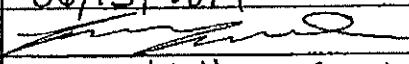
Name	Business Address/City/State/ZIP	EIN Number

**CERTIFICATION OF APPLICATION**

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 18-21-2-2.5 and IC 18-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	John Stutsman, Medical Director
Date of Signature (mm/dd/yyyy):	06/13/2017
Signature of the Clinic Administrator:	
Printed Name and Title:	Laura Miller Center Manager
Date of Signature (mm/dd/yyyy):	6/13/17

**See the following page for instructions regarding licensure fees and submission of this application.**

### License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	\$500.00
✓	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

**Enclose the following:**

1. A completed Application for License to Operate an Abortion Clinic (this form).
2. Any supporting attachments.
3. For each physician performing procedures, either:
  - (A) A copy (in writing) of the physician's admitting privileges; or
  - (B) A copy of:
    - (1) his/her written agreement with another physician with admitting privileges; and
    - (2) a copy (in writing) of that physician's admitting privileges.
4. Payment made payable to "Indiana State Department of Health."

**Mail to:**

INDIANA STATE DEPARTMENT OF HEALTH  
CASHIER'S OFFICE  
P. O. BOX 7236  
INDIANAPOLIS, INDIANA 46207-7236



RECEIVED  
MAY 30 2018

Planned Parenthood of Indiana and Kentucky

June 1, 2018

MD  
MD

Planned Parenthood of Indiana and Kentucky  
421 S College Ave  
Bloomington, IN 47403

Re: Backup Agreement for Monroe County

Drs. [redacted] and [redacted]

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation, or other medical need that requires hospitalization.

I have admitting privileges at [redacted] in [redacted], Indiana. As needed outside of usual care practices, I will arrange for patient admission and care according to each patient's need. As per Planned Parenthood of Indiana and Kentucky's guidelines and accepted medical standard of care, any patient needing immediate care should be evaluated at the closest emergency care center.

In the event my services are needed under this agreement, I have provided you with my phone number. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days' notice if I need to modify or cancel this agreement for any reason.

Sincerely,

**MEDICAL STAFF MEMBERSHIP OR AFFILIATION**  
**Primary Source Verification**

---

May 31, 2018

Randall D Snyder  
Division Director, Acute Care

RE: . MD

Dear Sir/Madam:

... facilities are committed to the provision of quality care and are accredited by The Joint Commission and/or Healthcare Facilities Accreditation Program. Our Ambulatory Surgery Centers are accredited by the Accreditation Association for Ambulatory Health Care. We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

**Facility:**

**Staff Appointment Date:** From: - Present

**Staff Status:**

**Department/Section:** Obstetrics & Gynecology

**Specialty:** Obstetrics & Gynecology

If you need additional information, please contact me.

Sincerely,

**MEDICAL STAFF MEMBERSHIP OR AFFILIATION**

**Primary Source Verification**

---

May 31, 2018

Randall D Snyder  
Division Director, Acute Care  
Indiana State Department of Health

RE: \_\_\_\_\_, MD

Dear Sir/Madam:

\_\_\_\_\_ facilities are committed to the provision of quality care and are accredited by The Joint Commission and/or Healthcare Facilities Accreditation Program. Our Ambulatory Surgery Centers are accredited by the Accreditation Association for Ambulatory Health Care. We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

**Facility:**

**Staff Appointment Date:** From: \_\_\_\_\_ Present

**Staff Status:**

**Department/Section:** Family Medicine

**Specialty:** Family Practice

If you need additional information, please contact me.

Sincerely,

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY

8590 GEORGETOWN ROAD

INDIANAPOLIS, INDIANA

Indiana State  
Department of Health  
*An Equal Opportunity Employer*

Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

May 31, 2018

Facility 011118

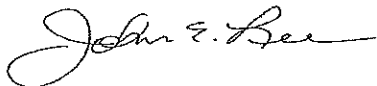
ANNJEANETTE BOTTOMS  
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC  
200 S. MERIDIAN STREET, SUITE 400  
INDIANAPOLIS, IN 46225

Dear ANNJJEANETTE BOTTOMS:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2018 through June 30, 2019.

Sincerely,



JOHN LEE, RN, MBA  
DEPUTY DIRECTOR OF ACUTE CARE  
ACUTE CARE DIVISION  
317/233-7487

Enclosure (1)

# Indiana State Department of Health

## Abortion Clinic License

*This is to certify that:*

Planned Parenthood Of Indiana and Kentucky d/b/a

**PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC**  
8590 GEORGETOWN RD  
INDIANAPOLIS, IN

*an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.*

*This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.*

*License number 18-0111118-1 is effective July 1, 2018 and expires June 30, 2019.*



*Randall Snyder*

RANDALL SNYDER PT, MBA  
DIRECTOR, ACUTE CARE DIVISION

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

RECEIVED  
MAY 30 2018

DATE 29-MAY-18

RECEIPT NO. 1834333

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 1,000.00  
Account: 423010, Department: 195129)

AMOUNT \$ 1,000.00 CASH

CHECKS AND 66937: \$1,000.00  
MONEY ORDERS

REFUND

MAIL CLERK  
Ford, Willia

REMARKS INDPLS IN

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

DATE 29-MAY-18

RECEIPT NO. 1834333

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 1,000.00  
Account: 423010, Department: 195129)

AMOUNT \$ 1,000.00

CASH

CHECKS AND 66937: \$1,000.00  
MONEY ORDERS

REFUND

MAIL CLERK  
Ford, Willia

REMARKS INDPLS IN

RECEIVED  
MAY 30 2018



**APPLICATION FOR LICENSE  
TO OPERATE AN ABORTION CLINIC**

State Form 52233 (R3 / 3-14)  
Approved by State Board of Accounts, 2014  
Indiana State Department of Health-Division of Acute Care  
(Pursuant to IC 16-21-2 and 410 IAC 26)

**Division of Acute Care Use Only**

Date Received (mm/dd/yyyy) \_\_\_\_\_ Date Approved (mm/dd/yyyy) \_\_\_\_\_ Date Rejected (mm/dd/yyyy) \_\_\_\_\_

Please Type or Print Legibly.

**SECTION I - TYPE OF APPLICATION**

Application (Check appropriate item.)

☐ New Facility ☒ Renewal

☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) \_\_\_\_\_  
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

**SECTION II - IDENTIFYING INFORMATION**

**A. Abortion Clinic Location**

Name of Abortion Clinic

Planned Parenthood of Indiana and Kentucky - Indianapolis

Street Address (number and street)

8590 Georgetown Road

City

Indianapolis

County

Marion

P.O. Box

ZIP Code +4

46268

Telephone Number

( 317 )  
872-3115

Fax Number

( 317 )  
872-3118

Abortion Clinic e-mail address: [annjeanette.bottoms@ppink.org](mailto:annjeanette.bottoms@ppink.org)

Internet Web Address: [www.ppink.org](http://www.ppink.org)

**B. Mailing Address (if different from abortion clinic location)**

Street Address (number and street)

200 S. Meridian Street, Suite 400

City

Indianapolis

County

Marion

P.O. Box

ZIP Code +4

46225

**C. Licensee/Ownership Information**

Licensee: The applicant entity as registered with the secretary of state

Planned Parenthood of Indiana and Kentucky, INC.

Street Address (number and street)

200 S. Meridian Suite 400

City

Indianapolis

State

Indiana

P.O. Box

ZIP Code+4

46225

Telephone Number

( 317 ) 637-4343

Fax Number

( 317 ) 637-4344

EIN Number

35-0874276

Fiscal Year End Date (mm/dd)

06/30

**G. Officers (if the business entity is incorporated)**

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Kim Green	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225
Vice-President/Vice-Chairperson/COO	Michael Carter	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225
Treasurer/CFO	Nathan Ringham	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225
Secretary	Christie Moore	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225

**H. Ownership and/or Change in Ownership:**

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (Use additional sheet if necessary.)

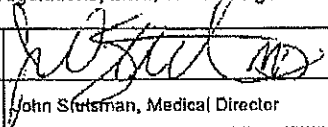
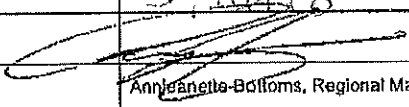
Name	Business Address/City/State/ZIP	EIN Number

**CERTIFICATION OF APPLICATION**

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	John Stutsman, Medical Director
Date of Signature (mm/dd/yyyy):	5/16/18
Signature of the Clinic Administrator:	
Printed Name and Title:	Annjanetta Bottoms, Regional Manager
Date of Signature (mm/dd/yyyy):	5/16/18

**See the following page for instructions regarding licensure fees and submission of this application.**

### License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	\$500.00
<input checked="" type="checkbox"/>	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

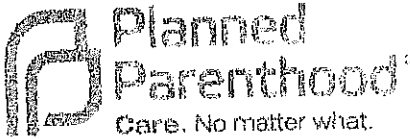
Indiana Hospital Council; 414 IAC 1-1-3

**Enclose the following:**

1. A completed Application for License to Operate an Abortion Clinic (this form).
2. Any supporting attachments.
3. For each physician performing procedures, either:
  - (A) A copy (in writing) of the physician's admitting privileges; or
  - (B) A copy of:
    - (1) his/her written agreement with another physician with admitting privileges; and
    - (2) a copy (in writing) of that physician's admitting privileges.
4. Payment made payable to "Indiana State Department of Health."

**Mail to:**

INDIANA STATE DEPARTMENT OF HEALTH  
CASHIER'S OFFICE  
P. O. BOX 7236  
INDIANAPOLIS, INDIANA 46207-7236



RECEIVED  
Indianapolis, IN 46225  
46206-0397  
MAY 30 2018

Planned Parenthood of Indiana and Kentucky

June 1, 2018

MD

MD

MD

MD

Planned Parenthood of Indiana and Kentucky  
8590 Georgetown Rd  
Indianapolis, IN 46268

Re: Backup Agreement for Marion County

Drs.

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation, or other medical need that requires hospitalization.

I have admitting privileges in Obstetrics and Gynecology at Indianapolis, Indiana. As needed outside of usual care practices, I will arrange for patient admission and care according to each patient's need. As per Planned Parenthood of Indiana and Kentucky's guidelines and accepted medical standard of care, any patient needing immediate care should be evaluated at the closest emergency care center.

In the event my services are needed under this agreement, I have provided you with my phone number. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days' notice if I need to modify or cancel this agreement for any reason.

Sincerely,

MD

**MEDICAL STAFF MEMBERSHIP OR AFFILIATION**  
**Primary Source Verification**

---

May 31, 2018

Randall D Snyder  
Division Director, Acute Care

RE: . MD

Dear Sir/Madam:

Our facilities are committed to the provision of quality care and are accredited by The Joint Commission and/or Healthcare Facilities Accreditation Program. Our Ambulatory Surgery Centers are accredited by the Accreditation Association for Ambulatory Health Care. We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

**Facility:**

**Staff Appointment Date:** From: - Present

**Staff Status:**

**Department/Section:** Obstetrics & Gynecology

**Specialty:** Obstetrics & Gynecology

If you need additional information, please contact me.

Sincerely,

**MEDICAL STAFF MEMBERSHIP OR AFFILIATION**  
**Primary Source Verification**

---

May 31, 2018

Randall D Snyder  
Division Director, Acute Care  
Indiana State Department of Health

RE: MD

Dear Sir/Madam:

Our facilities are committed to the provision of quality care and are accredited by The Joint Commission and/or Healthcare Facilities Accreditation Program. Our Ambulatory Surgery Centers are accredited by the Accreditation Association for Ambulatory Health Care. We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

**Facility:**

**Staff Appointment Date:** From: - Present

**Staff Status:**

**Department/Section:** Obstetrics & Gynecology

**Specialty:** Obstetrics & Gynecology

If you need additional information, please contact me.

Sincerely,

**MEDICAL STAFF MEMBERSHIP OR AFFILIATION**  
**Primary Source Verification**

---

May 31, 2018

Randall D Snyder  
Division Director, Acute Care  
Indiana State Department of Health

RE: \_\_\_\_\_, MD

Dear Sir/Madam:

\_\_\_\_\_ facilities are committed to the provision of quality care and are accredited by The Joint Commission and/or Healthcare Facilities Accreditation Program. Our Ambulatory Surgery Centers are accredited by the Accreditation Association for Ambulatory Health Care. We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

**Facility:**

**Staff Appointment Date:** From: \_\_\_\_\_ Present

**Staff Status:**

**Department/Section:** Family Medicine

**Specialty:** Family Practice

If you need additional information, please contact me.

Sincerely,

# Medical Staff Membership or Affiliation

05/31/2018

Randall D Snyder  
Division Director  
Indiana State Department of Health

Re:

is committed to the provision of quality care and is accredited by the Joint Commission. We engage in quality review activities for the purpose of concurrent and retrospective data collection, review and reporting. We continually monitor and evaluate the care our staff provides, including complication and mortality rates, number of admissions and procedures, peer review findings from drug usage evaluation, surgical case review, transfusion review, medical records review and departmental review, along with other indicators of the quality of care.

The practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Entity Name:  
Staff Appointment Date:  
Staff Status: Active  
Department: Family Medicine  
Category: Current  
Credentialed From Date: √  
Credentialed To Date:

---

Entity Name:  
Staff Appointment Date:  
Staff Status: Consulting  
Department: Family Medicine  
Category: Current  
Credentialed From Date:  
Credentialed To Date:

---

5/31/2018

Medical Staff Verification

Entity Name:  
Staff Appointment Date:  
Staff Status: Active  
Department: Family Medicine  
Category: Current  
Credentialed From Date:  
Credentialed To Date:

\*Please note effective , ) joined  
Effective joined the

Medical Staff. For information on these facilities prior to the dates listed above, please contact the Medical Staff Office.

Should you require additional information or if you have questions, please contact the Medical Staff Services Department at

Sincerely,  
Medical Staff Office

# Medical Staff Membership or Affiliation

05/31/2018

Randall D Snyder  
Division Director  
Indiana State Department of Health

Re: .

... is committed to the provision of quality care and is accredited by the Joint Commission. We engage in quality review activities for the purpose of concurrent and retrospective data collection, review and reporting. We continually monitor and evaluate the care our staff provides, including complication and mortality rates, number of admissions and procedures, peer review findings from drug usage evaluation, surgical case review, transfusion review, medical records review and departmental review, along with other indicators of the quality of care.

The practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

Entity Name:  
Staff Appointment Date:  
Staff Status: Active  
Department: Obstetrics & Gynecology  
Category: Current  
Credentialed From Date:  
Credentialed To Date:

---

Entity Name:  
Staff Appointment Date:  
Staff Status: Consulting  
Department: Obstetrics & Gynecology  
Category: Current  
Credentialed From Date:  
Credentialed To Date:

---

5/31/2018

Medical Staff Verification |

Entity Name:  
Staff Appointment Date:  
Staff Status: Active  
Department: Obstetrics & Gynecology  
Category: Current  
Credentialed From Date:  
Affiliation Termination Date:

\*Please note effective [redacted] joined the [redacted] Medical Staff. Effective [redacted] joined the [redacted] Medical Staff. For information on these facilities prior to the dates listed above, please contact the Medical Staff Office.

Should you require additional information or if you have questions, please contact the Medical Staff Services Department at [redacted]

Sincerely,  
Medical Staff Office

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY

964 MEZZANINE DRIVE

LAFAYETTE, INDIANA

  
Indiana State  
Department of Health  
*An Equal Opportunity Employer*

Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

May 31, 2018

Facility 013765

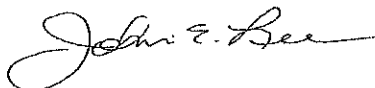
JACKIE KEY  
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC -  
200 S. MERIDIAN STREET, SUITE 400  
INDIANAPOLIS, IN 46225

Dear JACKIE KEY:

On behalf of the State Health Commissioner, and as provided  
for by state law, I hereby issue your license to operate an  
abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period  
July 1, 2018 through June 30, 2019.

Sincerely,



JOHN LEE, RN, MBA  
DEPUTY DIRECTOR OF ACUTE CARE  
ACUTE CARE DIVISION  
317/233-7487

Enclosure (1)

# Indiana State Department of Health

## Abortion Clinic License

*This is to certify that:*

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC - LAFAYETTE d/b/a  
**PLANNED PARENTHOOD OF INDIANA AND KENTUCKY, INC -**  
964 MEZZANINE DR  
LAFAYETTE, IN

*an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.*

*This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.*

*License number 18-013765-1 is effective July 1, 2018 and expires June 30, 2019.*



*Randall Snyder*

RANDALL SNYDER PT, MBA  
DIRECTOR, ACUTE CARE DIVISION

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

RECEIVED  
MAY 30 2018

DATE 29-MAY-18

RECEIPT NO. 1834335

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 500.00  
Account: 423010, Department: 195129)

AMOUNT	\$	500.00	CASH
--------	----	--------	------

CHECKS AND	66939:	\$500.00	
MONEY ORDERS			

REFUND

MAIL CLERK  
Ford, Willia

REMARKS LAFAYETTE IN

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

DATE	29-MAY-18	RECEIPT NO.	1834335
DIVISION	ACUTE CARE (AC)		
FROM	PLANNED PARENTHOOD		
STREET	PO BOX 397		
CITY	INDPLS	STATE IN	46206
LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, Account: 423010, Department: 195129)			500.00

AMOUNT	\$	500.00	CASH
CHECKS AND MONEY ORDERS	66939:	\$500.00	

REFUND

MAIL CLERK  
Ford, Willia

REMARKS LAFAYETTE IN

RECEIVED  
MAY 30 2018



**APPLICATION FOR LICENSE  
TO OPERATE AN ABORTION CLINIC**

State Form 52233 (R3 / 3-14)  
Approved by State Board of Accounts, 2014  
Indiana State Department of Health-Division of Acute Care  
(Pursuant to IC 16-21-2 and 410 IAC 26)

**Division of Acute Care Use Only**

Date Received (mm/dd/yyyy) \_\_\_\_\_ Date Approved (mm/dd/yyyy) \_\_\_\_\_ Date Rejected (mm/dd/yyyy) \_\_\_\_\_

Please Type or Print Legibly.

**SECTION I - TYPE OF APPLICATION**

Application (Check appropriate item.)

☐ New Facility    ☒ Renewal    ☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) \_\_\_\_\_  
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

**SECTION II - IDENTIFYING INFORMATION**

**A. Abortion Clinic Location**

Name of Abortion Clinic

Planned Parenthood of Indiana and Kentucky - Lafayette

Street Address (number and street)

964 Mezzanine Drive

P.O. Box

City

Lafayette

County

Tipton

ZIP Code +4

47905

Telephone Number

( 765 )

446-8078

Fax Number

( 765 )

446-8160

Abortion Clinic e-mail address: [jackie.marshall@ppink.org](mailto:jackie.marshall@ppink.org)

Internet Web Address: [www.ppink.org](http://www.ppink.org)

**B. Mailing Address (if different from abortion clinic location)**

Street Address (number and street)

200 S. Meridian Street, Suite 400

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46225

**C. Licensee/Ownership Information**

Licensee: The applicant entity as registered with the secretary of state

Planned Parenthood of Indiana and Kentucky, INC.

Street Address (number and street)

200 S. Meridian Suite 400

P.O. Box

City

Indianapolis

State

Indiana

ZIP Code+4

46225

Telephone Number

( 317 ) 637-4343

Fax Number

( 317 ) 637-4344

EIN Number

35-0874276

Fiscal Year End Date (mm/dd)

06/30

**D. Services provided under this license:**

Code items 1 and 2 as follows: 1. Provided directly by employee(s), 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: ☒ Laboratory: CLIA Certificate Number 1500360690 ☐ Radiology ☐ Counseling

☒ Family Planning ☐ Pharmacy ☐ Other (List): \_\_\_\_\_

2. Surgical Services: ☒ Gynecology ☐ Other (List): \_\_\_\_\_

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: ☒ Registered Nurses: ☒ Licensed Practical Nurses: ☒

Licensed Social Workers: ☒ Other (List title and number): 1 Health Center Manager 2 Health Center Assistant \_\_\_\_\_

**E. Number of Procedure Rooms Utilizing:**

Local analgesia/anesthetic ☒

Moderate/Conscious Sedation ☒

**F. Type of Entity:**

For Profit

- ☐ Individual  
☐ Partnership  
☐ Corporation  
☐ Limited Liability Company  
☐ Sole Proprietorship  
☐ Other (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Non-Profit

- ☐ Church Related  
☐ Individual  
☐ Partnership  
☒ Corporation  
☐ Limited Liability Company  
☐ Other (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Government

- ☐ State  
☐ County  
☐ City  
☐ City/County  
☐ Hospital District  
☐ Federal  
☐ Other (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**G. Officers (if the business entity is incorporated)**

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Kim Green	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225
Vice-President/Vice-Chairperson/COO	Michael Carter	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225
Treasurer/CFO	Nathan Ringham	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225
Secretary	Christie Moore	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225

**H. Ownership and/or Change in Ownership:**

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (Use additional sheet if necessary.)

Name	Business Address/City/State/ZIP	EIN Number

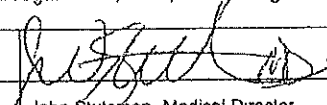
**CERTIFICATION OF APPLICATION**

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:



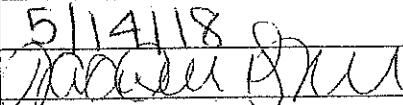
Printed Name and Title:

John Stuteman, Medical Director

Date of Signature (mm/dd/yyyy):

5/14/18

Signature of the Clinic Administrator:



Printed Name and Title:

Jackie Marshall, Health Center Manager

Date of Signature (mm/dd/yyyy):

05/14/2018

**See the following page for instructions regarding licensure fees and submission of this application.**

### License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
<input checked="" type="checkbox"/>	Zero to 799	\$500.00
<input type="checkbox"/>	800 to 3,499	\$1,000.00
<input type="checkbox"/>	3,500 to 6,999	\$2,000.00
<input type="checkbox"/>	7,000 and above	\$3,000.00

Indiana Hospital Council; 414 IAC 1-1-3

**Enclose the following:**

1. A completed Application for License to Operate an Abortion Clinic (this form).
2. Any supporting attachments.
3. For each physician performing procedures, either:
  - (A) A copy (in writing) of the physician's admitting privileges; or
  - (B) A copy of:
    - (1) his/her written agreement with another physician with admitting privileges; and
    - (2) a copy (in writing) of that physician's admitting privileges.
4. Payment made payable to "Indiana State Department of Health."

**Mail to:**

INDIANA STATE DEPARTMENT OF HEALTH  
CASHIER'S OFFICE  
P. O. BOX 7236  
INDIANAPOLIS, INDIANA 46207-7236



RECEIVED  
JUN 11 2018

Planned Parenthood of Indiana and Kentucky

June 1, 2018

MD

MD

MD

Planned Parenthood of Indiana and Kentucky  
964 Mezzanine Dr  
Lafayette, IN 47905

Re: Backup Agreement for Tippecanoe County

Drs.

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation, or other medical need that requires hospitalization.

I have admitting privileges in Obstetrics and Gynecology at

As needed outside of usual care practices, I will arrange for patient admission and care according to each patient's need. As per Planned Parenthood of Indiana and Kentucky's guidelines and accepted medical standard of care, any patient needing immediate care should be evaluated at the closest emergency care center.

In the event my services are needed under this agreement, I have provided you with my phone number. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days' notice if I need to modify or cancel this agreement for any reason.

Sincerely,

MD

RECEIVED  
MAY 30 2018

**MEDICAL STAFF MEMBERSHIP OR AFFILIATION**  
**Primary Source Verification**

---

November 01, 2017

Medical Director  
Planned Parenthood of Indiana & Kentucky

RE: MD

Dear Sir/Madam:

Our facilities are committed to the provision of quality care and are accredited by The Joint Commission and/or Healthcare Facilities Accreditation Program. Our Ambulatory Surgery Centers are accredited by the Accreditation Association for Ambulatory Health Care. We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

**Facility:**

**Staff Appointment Date:** From: - Present

**Staff Status:** Associate

**Department/Section:** Obstetrics & Gynecology

**Specialty:** Obstetrics & Gynecology

If you need additional information, please contact me.

Sincerely,

**MEDICAL STAFF MEMBERSHIP OR AFFILIATION**  
**Primary Source Verification**

---

May 31, 2018

Randall D Snyder  
Division Director, Acute Care  
Indiana State Department of Health

RE: MD

Dear Sir/Madam:

facilities are committed to the provision of quality care and are accredited by The Joint Commission and/or Healthcare Facilities Accreditation Program. Our Ambulatory Surgery Centers are accredited by the Accreditation Association for Ambulatory Health Care. We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

**Facility:**

**Staff Appointment Date:** From: - Present

**Staff Status:** Associate

**Department/Section:** Obstetrics & Gynecology

**Specialty:** Obstetrics & Gynecology

If you need additional information, please contact me.

Sincerely,

PLANNED PARENTHOOD OF INDIANA AND KENTUCKY

8645 CONNECTICUT STREET

MERRILLVILLE, INDIANA

Indiana State  
Department of Health  
*An Equal Opportunity Employer*

Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

May 31, 2018

Facility 011116

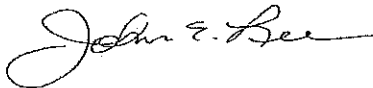
JESSICA STIENBARGER, MANAGER  
PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC  
200 S. MERIDIAN STREET, SUITE 400  
INDIANAPOLIS, IN 46225

Dear JESSICA STIENBARGER, MANAGER:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2018 through June 30, 2019.

Sincerely,



JOHN LEE, RN, MBA  
DEPUTY DIRECTOR OF ACUTE CARE  
ACUTE CARE DIVISION  
317/233-7487

Enclosure (1)

# Indiana State Department of Health

## Abortion Clinic License

*This is to certify that:*

Planned Parenthood Of Indiana and Kentucky INC d/b/a

**PLANNED PARENTHOOD OF INDIANA AND KENTUCKY INC**  
8645 CONNECTICUT ST  
MERRILLVILLE, IN

*an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.*

*This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.*

*License number 18-0111116-1 is effective July 1, 2018 and expires June 30, 2019.*



*Randall Snyder*

RANDALL SNYDER PT, MBA  
DIRECTOR, ACUTE CARE DIVISION

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

RECEIVED  
MAY 30 2018

DATE 29-MAY-18

RECEIPT NO. 1834332

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 1,000.00  
Account: 423010, Department: 195129)

AMOUNT	\$	1,000.00	CASH
--------	----	----------	------

CHECKS AND	66940:	\$1,000.00
MONEY ORDERS		

REFUND

MAIL CLERK  
Ford, Willia

REMARKS MERRILLVILLE

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

DATE 29-MAY-18

RECEIPT NO. 1834332

DIVISION ACUTE CARE (AC)

FROM PLANNED PARENTHOOD

STREET PO BOX 397

CITY INDPLS

STATE IN

46206

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 1,000.00  
Account: 423010, Department: 195129)

AMOUNT \$ 1,000.00

CASH

CHECKS AND 66940: \$1,000.00  
MONEY ORDERS

REFUND

MAIL CLERK  
Ford, Willia

REMARKS MERRILLVILLE



**APPLICATION FOR LICENSE  
TO OPERATE AN ABORTION CLINIC**

State Form 52233 (R3 / 3-14)  
Approved by State Board of Accounts, 2014  
Indiana State Department of Health-Division of Acute Care  
(Pursuant to IC 16-21-2 and 410 IAC 26)

**RECEIVED**  
MAY 30 2018

**Division of Acute Care Use Only**

Date Received (mm/dd/yyyy) \_\_\_\_\_ Date Approved (mm/dd/yyyy) \_\_\_\_\_ Date Rejected (mm/dd/yyyy) \_\_\_\_\_

*Please Type or Print Legibly.*

**SECTION I - TYPE OF APPLICATION**

Application (Check appropriate item.)

☐ New Facility ☒ Renewal ☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) \_\_\_\_\_  
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

**SECTION II - IDENTIFYING INFORMATION**

**A. Abortion Clinic Location**

Name of Abortion Clinic

Planned Parenthood of Indiana and Kentucky - Merrillville

Street Address (number and street)

8645 Connecticut Street

P.O. Box

City

Merrillville

County

Lake

ZIP Code +4

46410

Telephone Number

( 219 )

769-3500

Fax Number

( 219 )

791-0538

Abortion Clinic e-mail address: stephanie.navarro@ppink.org

Internet Web Address: www.ppink.org

**B. Mailing Address (if different from abortion clinic location)**

Street Address (number and street)

200 S. Meridian Street, Suite 400

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46225

**C. Licensee/Ownership Information**

Licensee: The applicant entity as registered with the secretary of state

Planned Parenthood of Indiana and Kentucky, INC.

Street Address (number and street)

200 S. Meridian Suite 400

P.O. Box

City

Indianapolis

State

Indiana

ZIP Code+4

46225

Telephone Number

( 317 ) 637-4343

Fax Number

( 317 ) 637-4344

EIN Number

35-0874276

Fiscal Year End Date (mm/dd)

06/30

**D. Services provided under this license:**

Code items 1 and 2 as follows: 1. Provided directly by employee(s), 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: ☒ Laboratory: CLIA Certificate Number 1500360690 ☐ Radiology ☐ Counseling

☒ Family Planning ☐ Pharmacy ☐ Other (List): \_\_\_\_\_

2. Surgical Services: ☒ Gynecology ☐ Other (List): \_\_\_\_\_

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: ☒ Registered Nurses: ☒ Licensed Practical Nurses: ☒

Licensed Social Workers: ☒ Other (List title and number): 1 APRN, 1 Health Center Manager, 6 Health Center Assistants

**E. Number of Procedure Rooms Utilizing:**

Local analgesia/anesthetic ☒ Moderate/Conscious Sedation ☒

**F. Type of Entity:**

For Profit

- ☐ Individual  
☐ Partnership  
☐ Corporation  
☐ Limited Liability Company  
☐ Sole Proprietorship  
☐ Other (specify) \_\_\_\_\_

Non-Profit

- ☐ Church Related  
☐ Individual  
☐ Partnership  
☒ Corporation  
☐ Limited Liability Company  
☐ Other (specify) \_\_\_\_\_

Government

- ☐ State  
☐ County  
☐ City  
☐ City/County  
☐ Hospital District  
☐ Federal  
☐ Other (specify) \_\_\_\_\_

**G. Officers (if the business entity is incorporated)**

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Kim Green	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225
Vice-President/Vice-Chairperson/COO	Michael Carter	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225
Treasurer/CFO	Nathan Ringham	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225
Secretary	Christie Moore	200 S. Meridian Street, Suite 400 Indianapolis, IN 46225

**H. Ownership and/or Change in Ownership:**

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (Use additional sheet if necessary.)

Name	Business Address/City/State/ZIP	EIN Number

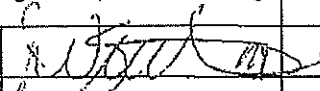
**CERTIFICATION OF APPLICATION**

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:



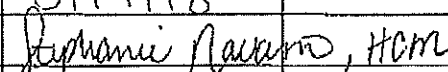
Printed Name and Title:

John Stutsman, Medical Director

Date of Signature (mm/dd/yyyy):

5/14/18

Signature of the Clinic Administrator:



Printed Name and Title:

Stephanie Navarro, Health Center Manager

Date of Signature (mm/dd/yyyy):

5/14/18

**See the following page for instructions regarding licensure fees and submission of this application.**

### License Fee

Select the appropriate fee based upon the total number of first trimester procedures as reported to the Indiana State Department of Health (ISDH) on the Terminated Pregnancy Report (State Form 36526).

Check One	Total First Trimester Procedures in the Clinic	Fee
	Zero to 799	\$500.00
✓	800 to 3,499	\$1,000.00
	3,500 to 6,999	\$2,000.00
	7,000 and above	\$3,000.00

*Indiana Hospital Council; 414 IAC 1-1-3*

***Enclose the following:***

- 1. A completed Application for License to Operate an Abortion Clinic (this form).***
- 2. Any supporting attachments.***
- 3. For each physician performing procedures, either:***
  - (A) A copy (in writing) of the physician's admitting privileges; or***
  - (B) A copy of:***
    - (1) his/her written agreement with another physician with admitting privileges; and***
    - (2) a copy (in writing) of that physician's admitting privileges.***
- 4. Payment made payable to "Indiana State Department of Health."***

***Mail to:***

INDIANA STATE DEPARTMENT OF HEALTH  
CASHIER'S OFFICE  
P. O. BOX 7236  
INDIANAPOLIS, INDIANA 46207-7236

MAY/14/2018/MON 02:19

FAX No.

RECEIVED  
MAY 30 2018



Planned Parenthood of Indiana and Kentucky

June 1, 2018

, MD  
MD  
MD  
MD  
MD

Planned Parenthood of Indiana and Kentucky  
8645 Connecticut St  
Merrillville, IN 46410

Re: Backup Agreement for Lake County

Drs. , and

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation, or other medical need that requires hospitalization.

I have admitting privileges in Obstetrics and Gynecology at

As needed outside of usual care practices, I will arrange for patient admission and care according to each patient's need. As per Planned Parenthood of Indiana and Kentucky's guidelines and accepted medical standard of care, any patient needing immediate care should be evaluated at the closest emergency care center.

In the event my services are needed under this agreement, I have provided you with my phone number. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days' notice if I need to modify or cancel this agreement for any reason.

Sincerely,

April 27, 2018

, MD

Valparaiso, IN

Dear Dr.

On behalf of the Board of Trustees, it is my pleasure to inform you that your reappointment to the Medical Staff has been approved. You have been granted membership on the Active staff with clinical privileges in Obstetrics & Gynecology beginning through

Clinical privileges have been granted as specified on the enclosed Delineation of Privileges form. Please review these carefully, as you have only been granted privileges to perform those procedures outlined on your Delineation of Privileges form.

As a member of the Medical Staff, you are required to abide by all hospital policies and the Code of Ethical Conduct. Your reappointment is subject to the terms and conditions of the Medical Staff Bylaws, Rules and Regulations and all other Medical Staff Policies and Procedures that are in force during the term of your appointment.

Should you have any questions regarding your appointment or your current privileges, please do not hesitate to contact the Medical Staff Office for assistance at

We appreciate your continued support and value your contribution as a member of the Medical Staff

Sincerely,

Enclosure: Clinical Privileges

April 27, 2018

Phone verified 5/2/18 =  
1:42 pm

MD

DIRL

MED STAFF OFFICE

*RS*

Valparaiso, IN

Dear Dr.

On behalf of the Board of Trustees, it is my pleasure to inform you that your reappointment to the Medical Staff has been approved. You have been granted membership on the Active staff with clinical privileges in Obstetrics & Gynecology beginning through

Clinical privileges have been granted as specified on the enclosed Delineation of Privileges form. Please review these carefully, as you have only been granted privilege to perform those procedures outlined on your Delineation of Privileges form.

As a member of the Medical Staff, you are required to abide by all hospital policies and the Code of Ethical Conduct. Your reappointment is subject to the terms and conditions of the Medical Staff Bylaws, Rules and Regulations and all other Medical Staff Policies and Procedures that are in force during the term of your appointment.

Should you have any questions regarding your appointment or your current privileges, please do not hesitate to contact the Medical Staff Office for assistance at (219) 983-8566.

We appreciate your continued support and value your contribution as a member of the Medical Staff.

Sincerely,

Enclosure: Clinical Privileges

WOMEN'S MED GROUP PROFESSIONAL CORPORATION

1201 N. ARLINGTON AVENUE

INDIANAPOLIS, INDIANA

 Indiana State  
Department of Health  
*An Equal Opportunity Employer*

Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

June 19, 2018

Facility 011128

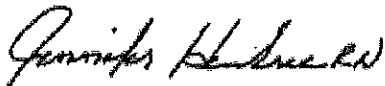
W. MARTIN HASKELL, M.D.  
WOMEN'S MED GROUP PROFESSIONAL CORPORATION  
PO BOX 43100  
CINCINNATI, OH 45243

Dear W. MARTIN HASKELL, M.D.:

On behalf of the State Health Commissioner, and as provided for by state law, I hereby issue your license to operate an abortion clinic as defined in Indiana code 16-21.

Enclosed is your license which is valid for the period July 1, 2017 through June 30, 2018.

Sincerely,



JENNIFER HEMBREE RN  
Nurse Surveyor Supervisor  
Program Director Hospitals/ASCs  
317/232-3095

Enclosure (1)

# Indiana State Department of Health

## Abortion Clinic License

*This is to certify that:*

Women's Med Group Professional Corporation d/b/a  
**WOMEN'S MED GROUP PROFESSIONAL CORPORATION**  
1201 N ARLINGTON AVE  
INDIANAPOLIS, IN

an Abortion Clinic, has fulfilled the requirements for licensure and is subject to provisions of IC 16-21 and the rules of the Indiana State Department of Health issued thereunder.

This license shall not be assignable or transferable, and shall be subject to revocation at any time by the Indiana State Department of Health for failure to comply with the laws of the State of Indiana or the rules of the Indiana State Department of Health issued thereunder.

License number 17-011128-1 is effective July 1, 2017 and expires June 30, 2018.



*Randall Snyder*

RANDALL SNYDER PT, MBA  
DIRECTOR, ACUTE CARE DIVISION

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

RECEIVED  
JUN 18 2018

RECEIPT NO. 1835636

DATE 13-JUN-18

DIVISION ACUTE CARE (AC)

FROM THE WOMENS MED+ CENTER LTD

STREET PO BOX 43100

CITY CINBCINNATI

STATE OH

45243

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 1,000.00  
Account: 423010, Department: 195129)

AMOUNT	\$	1,000.00	CASH
CHECKS AND MONEY ORDERS	60191:	\$1,000.00	

REFUND

MAIL CLERK  
Ford, Willia

REMARKS

INDIANA STATE DEPARTMENT OF HEALTH  
MAIL MONEY RECEIPT

DATE 13-JUN-18

RECEIPT NO. 1835636

DIVISION ACUTE CARE (AC)

FROM THE WOMENS MED+ CENTER LTD

STREET PO BOX 43100

CITY CINBCINNATI

STATE OH

45243

LICENSE TO OPERATE ABORTION CLINIC (Fund:17610, Program: 30000, 1,000.00  
Account: 423010, Department: 195129)

AMOUNT \$ 1,000.00

CASH

CHECKS AND 60191: \$1,000.00  
MONEY ORDERS

REFUND

MAIL CLERK  
Ford, Willia

REMARKS

RECEIVED  
JUN 18 2018



**APPLICATION FOR LICENSE  
TO OPERATE AN ABORTION CLINIC**

State Form 52233 (R3 / 3-14)  
Approved by State Board of Accounts, 2014  
Indiana State Department of Health-Division of Acute Care  
(Pursuant to IC 16-21-2 and 410 IAC 26)

**Division of Acute Care Use Only**

Date Received (mm/dd/yyyy) \_\_\_\_\_ Date Approved (mm/dd/yyyy) \_\_\_\_\_ Date Rejected (mm/dd/yyyy) \_\_\_\_\_

Please Type or Print Legibly.

**SECTION I - TYPE OF APPLICATION**

Application (Check appropriate item.)

☐ New Facility ☒ Renewal

☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease (mm/dd/yyyy)) \_\_\_\_\_  
Submit a dated and signed copy of the bill of sale, lease or other document of transfer.

**SECTION II - IDENTIFYING INFORMATION**

**A. Abortion Clinic Location**

Name of Abortion Clinic

Women's Med Group Professional Corporation

Street Address (number and street)

1201 N Arlington Ave

P.O. Box

City

Indianapolis

County

Marion

ZIP Code +4

46219

Telephone Number

(317)

353 9371

Fax Number

(317)

322 3358

Abortion Clinic e-mail address: martyh@fortemgt.com

Internet Web Address: www.womensmed.com

**B. Mailing Address (if different from abortion clinic location)**

Street Address (number and street)

P.O. Box

43100

City

Cincinnati, OH

County

Hamilton

ZIP Code +4

45243

**C. Licensee/Ownership Information**

Licensee: The applicant entity as registered with the secretary of state

Women's Med Group Professional Corporation

Street Address (number and street)

P.O. Box

43100

City

Cincinnati

State

OH

ZIP Code+4

45243

Telephone Number

(513) 272 0002

Fax Number

(513) 272 0052

EIN Number

31-1148155

Fiscal Year End Date (mm/dd)

12/31

**D. Services provided under this license:**

Code items 1 and 2 as follows: 1. Provided directly by employee(s), 2. Provided by a contract service, 3. Both 1 and 2.

1. Ancillary Services: ☒ Laboratory: CLIA Certificate Number 15D353797 ☒ Radiology ☒ Counseling  
☒ Family Planning ☒ Pharmacy ☐ Other (List): \_\_\_\_\_

2. Surgical Services: ☒ Gynecology ☐ Other (List): \_\_\_\_\_

For item 3, indicate the total number of individuals (employees plus contractors) working in this clinic. This includes hourly, part-time, and full-time persons.

3. Staffing : Physicians: ☒ Registered Nurses: ☒ Licensed Practical Nurses: ☒  
Licensed Social Workers: ☒ Other (List title and number): Medical Assistants 5

**E. Number of Procedure Rooms Utilizing:**

Local analgesia/anesthetic ☒ Moderate/Conscious Sedation ☒

**F. Type of Entity:**

For Profit

- ☐ Individual  
☐ Partnership  
☒ Corporation  
☐ Limited Liability Company  
☐ Sole Proprietorship  
☐ Other (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Non-Profit

- ☐ Church Related  
☐ Individual  
☐ Partnership  
☐ Corporation  
☐ Limited Liability Company  
☐ Other (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Government

- ☐ State  
☐ County  
☐ City  
☐ City/County  
☐ Hospital District  
☐ Federal  
☐ Other (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**G. Officers (if the business entity is incorporated)**

Position	Name	Address/City/State/ZIP
President/Chairperson/CEO	Martin Haskell, MD	PO Box 43100 Cincinnati, OH 45243
Vice-President/Vice-Chairperson/COO	Valerie Haskell	PO Box 43100 Cincinnati, OH 45243
Treasurer/CFO	Martin Haskell, MD	PO Box 43100 Cincinnati, OH 45243
Secretary	Valerie Haskell	PO Box 43100 Cincinnati, OH 45243

**H. Ownership and/or Change in Ownership:**

List names and addresses of individuals or organizations having direct or indirect ownership or controlling interest of five percent (5%) in the applicant entity. Indirect ownership interest is an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. (Use additional sheet if necessary.)

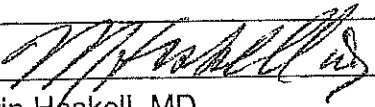
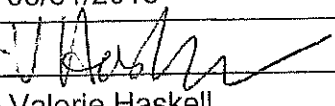
Name	Business Address/City/State/ZIP	EIN Number
Martin Haskell, MD	PO Box 43100, Cincinnati, OH 45243	

**CERTIFICATION OF APPLICATION**

The undersigned hereby makes application for a license to operate an Abortion Clinic (Clinic) in the State of Indiana, and in support of this application, represents and shows that the owner(s) and operator(s) are of reputable and reasonable character, are able to comply with the Abortion Clinic statutes, IC 16-21-2-2.5 and IC 16-34, and the rules promulgated there under, 410 IAC 26 and will operate and maintain this clinic in accordance with those rules.

I certify that the operational policies of the clinic will not provide for discrimination based upon race, color, creed, or national origin.

I swear and affirm under the penalty of perjury that all statements made in this application and any attachments thereto are correct and complete and that I will comply with all regulations, laws, and rules governing the licensing of clinics in Indiana.

Signature of the Medical Director:	
Printed Name and Title:	Martin Haskell, MD
Date of Signature (mm/dd/yyyy):	05/31/2018
Signature of the Clinic Administrator:	
Printed Name and Title:	Valerie Haskell
Date of Signature (mm/dd/yyyy):	05/31/2018

**See the following page for instructions regarding licensure fees and submission of this application.**

RECEIVED  
APR 18 2018

April 2, 2018

MD  
Indianapolis Women's Center  
1401 N. Arlington Ave  
Indianapolis, IN 46219

RE: Backup Agreement

Dear Dr. :

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation or other medical need that requires hospitalization.

I have staff privileges in Obstetrics and Gynecology at i  
I, or one of my partners, will arrange patient admission and care for each patient needing my services according to each patient's need.

In the event my services are needed under this agreement, contact me by calling my office at

In addition, I have provided you with my cell phone and pager numbers.

Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days notice if I need to modify or cancel this agreement for any reason.

MD

April 2, 2018

MD  
Indianapolis Women's Center  
1401 N. Arlington Ave  
Indianapolis, IN 46219

RE: Backup Agreement

Dear Dr. .

This letter confirms our agreement that I will provide emergency back-up services for your abortion patients in the event of a complication, emergency situation or other medical need that requires hospitalization.

I have staff privileges in Obstetrics and Gynecology at  
I, or one of my partners, will arrange patient admission and care for each patient needing my services according to each patient's need.

In the event my services are needed under this agreement, contact me by calling my office at . In addition, I have provided you with my cell phone and pager numbers. Please provide the patient's name, reason for referral, current medical condition and means of transport. A copy of all available patient records should be sent with the patient.

I agree to provide you thirty (30) days notice if I need to modify or cancel this agreement for any reason.

MD

RECEIVED  
JUN 16 2019

November 01, 2016

, MD  
Department of OB/GYN

RE: Membership and Clinical Privileges

Dear , MD:

I am pleased to inform you that your Application for Reappointment and Request for Clinical Privileges to , MD which includes , have been approved by the Board of Directors for , to , as a Associate member of the Medical Staff.

is committed to providing a safe environment and to meeting the medical and emotional needs of patients, families, visitors, employees, and staff. Members of the Medical/Allied Health Staff are obliged to carry themselves in such a manner which exemplifies the utmost respect and professionalism. By receipt of this letter and the attached copy of Code of Conduct Policy, you agree to abide by this policy.

If you have any questions regarding your appointment, please contact your supervising physician or the Medical Staff Services Office at the number below.

Sincerely,

Primary Source Verification

---

June 19, 2018

Randall D Snyder  
Division Director, Acute Care  
Indiana State Department of Health

RE: \_\_\_\_\_, MD

Dear Sir/Madam:

\_\_\_\_\_ facilities are committed to the provision of quality care and are accredited by The Joint Commission and/or Healthcare Facilities Accreditation Program. Our Ambulatory Surgery Centers are accredited by the Accreditation Association for Ambulatory Health Care. We engage in peer review, quality management activities, ongoing professional practice evaluation and focused professional practice evaluation. We monitor our practitioners in six areas of general competency - patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The above practitioner has met the necessary requirements to maintain clinical privileges and membership on the Medical/Dental/Allied Health Staff including professional, moral, ethical and physical requirements.

**Facility:**

**Staff Appointment Date:** From: \_\_\_\_\_ - Present

**Staff Status:** Associate

**Department/Section:** Obstetrics & Gynecology

**Specialty:** Obstetrics & Gynecology

If you need additional information, please contact me.

Sincerely,

HOSPITAL MAILING LIST  
AGREEMENTS AND PRIVILEGES



Eric J. Holcomb  
*Governor*

Kristina Box, MD, FACOG  
*State Health Commissioner*

July 9, 2018

Luis Molina, Administrator  
Community Hospital  
901 Macarthur Blvd  
Munster, In 46321

Dear administrator:

**The enclosed documents were not sent in error.** Community Hospital is receiving these documents as required by law pursuant to Indiana code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/

Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Scott Teffeteller, Administrator  
Community Hospital East  
1500 N Ritter Ave  
Indianapolis, In 46219

Dear Administrator:

**The enclosed documents were NOT sent in error.** Community Hospital East is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/

Randall Snyder, PT., MBA  
Division Director  
Acute Care



Indiana State  
Department of Health  
*An Equal Opportunity Employer*

Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Kathleen Krusie, Administrator  
Community Hospital North  
7150 Clearvista Dr  
Indianapolis, In 46256

Dear Administrator:

**The enclosed documents were NOT sent in error.** Community Hospital North is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/

Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

David Kiley, Administrator  
Community Hospital South  
1402 E County Line Rd S  
Indianapolis, In 46227

Dear Administrator:

**The enclosed documents were NOT sent in error.** Community Hospital South is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Lisa Harris, Administrator  
Eskenazi Health  
720 Eskenazi Avenue  
Indianapolis, In 46202

Dear Administrator:

**The enclosed documents were NOT sent in error.** Eskenazi Health is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Indiana State  
Department of Health  
*An Equal Opportunity Employer*

Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

James Callaghan Iii, Administrator  
Franciscan Health Carmel  
12188 B North Meridian Street  
Carmel, In 46032

Dear Administrator:

**The enclosed documents were NOT sent in error.** Franciscan Health Carmel is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/

Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Terrence Klein, Administrator  
Franciscan Health Crawfordsville  
1710 Lafayette Rd  
Crawfordsville, In 47933

Dear Administrator:

**The enclosed documents were NOT sent in error.** Franciscan Health Crawfordsville is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/

Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Daniel McCormick, Administrator  
Franciscan Health Crown Point  
1201 S Main St  
Crown Point, In 46307

Dear Administrator:

**The enclosed documents were NOT sent in error.** Franciscan Health Crown Point is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Patrick Maloney, Administrator  
Franciscan Health Dyer  
24 Joliet St  
Dyer, In 46311

Dear Administrator:

**The enclosed documents were NOT sent in error.** Franciscan Health Dyer is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Indiana State  
Department of Health  
*An Equal Opportunity Employer*

Eric J. Holcomb  
*Governor*

Kristina Box, MD, FACOG  
*State Health Commissioner*

July 9, 2018

Patrick Maloney, Administrator  
Franciscan Health Hammond  
5454 Hohman Ave  
Hammond, In 46320

Dear Administrator:

**The enclosed documents were NOT sent in error.** Franciscan Health Hammond is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/

Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

James Callaghan III, Administrator  
Franciscan Health Indianapolis  
8111 S Emerson Ave  
Indianapolis, IN 46237

Dear Administrator:

**The enclosed documents were NOT sent in error.** Franciscan Health Indianapolis is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Terrance Wilson, Administrator  
Franciscan Health Lafayette  
1701 S Creasy Ln  
Lafayette, In 47905

Dear Administrator:

**The enclosed documents were NOT sent in error.** Franciscan Health Lafayette is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

James Callaghan III, Administrator  
Franciscan Health Mooresville  
1201 Hadley Rd  
Mooresville, IN 46158

Dear Administrator:

**The enclosed documents were NOT sent in error.** Franciscan Health Mooresville is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Patrick Maloney, Administrator  
Franciscan Health Munster  
701 Superior Ave  
Munster, In 46321

Dear Administrator:

**The enclosed documents were NOT sent in error.** Franciscan Health Munster is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Terrance Wilson, Administrator  
Franciscan Health Rensselaer, Inc  
1104 E Grace St  
Rensselaer, In 47978

Dear Administrator:

**The enclosed documents were NOT sent in error.** Franciscan Health Rensselaer, Inc is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Brenda Reetz, Administrator  
Greene County General Hospital  
1185 N 1000 W  
Linton, In 47441

Dear Administrator:

**The enclosed documents were NOT sent in error.** Greene County General Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Stephen Long, Administrator  
Hancock Regional Hospital  
801 N State St  
Greenfield, In 46140

Dear Administrator:

**The enclosed documents were NOT sent in error.** Hancock Regional Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Kevin Speer, Administrator  
Hendricks Regional Health  
1000 E Main St  
Danville, In 46122

Dear Administrator:

**The enclosed documents were NOT sent in error.** Hendricks Regional Health is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Dennis Murphy, Administrator  
Indiana University Health  
1701 N Senate Blvd  
Indianapolis, In 46202

Dear Administrator:

**The enclosed documents were NOT sent in error.** Indiana University Health is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Daniel Neufelder, Administrator  
Indiana University Health Arnett Hospital  
5165 Mccarty Ln  
Lafayette, In 47905

Dear Administrator:

**The enclosed documents were NOT sent in error.** Indiana University Health Arnett Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Bradford Dykes, Administrator  
Indiana University Health Bedford Hospital  
2900 W 16th St  
Bedford, In 47421

Dear Administrator:

**The enclosed documents were NOT sent in error.** Indiana University Health Bedford Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Kelly Braverman, Administrator  
Indiana University Health Frankfort Inc  
1300 S Jackson St  
Frankfort, In 46041

Dear Administrator:

**The enclosed documents were NOT sent in error.** Indiana University Health Frankfort Inc is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Alicia Schulhof, Administrator  
Indiana University Health North Hospital  
11700 N Meridian St  
Carmel, In 46032

Dear Administrator:

**The enclosed documents were NOT sent in error.** Indiana University Health North Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Mary Minier, Administrator  
Indiana University Health White Memorial Hospital  
720 South Sixth St  
Monticello, In 47960

Dear Administrator:

**The enclosed documents were NOT sent in error.** Indiana University Health White Memorial Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Brian Shockney, Administrator  
Iu Health Bloomington Hospital  
601 W Second St  
Bloomington, In 47403

Dear Administrator:

**The enclosed documents were NOT sent in error.** Iu Health Bloomington Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Doug Puckett, Administrator  
Iu Health West Hospital  
1111 N Ronald Reagan Pkwy  
Avon, In 46123

Dear Administrator:

**The enclosed documents were NOT sent in error.** Iu Health West Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Larry Heydon, Administrator  
Johnson Memorial Hospital  
1125 W Jefferson St  
Franklin, In 46131

Dear Administrator:

**The enclosed documents were NOT sent in error.** Johnson Memorial Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

John Horner, Administrator  
Major Hospital  
2451 Intelliplex Dr  
Shelbyville, In 46176

Dear Administrator:

**The enclosed documents were NOT sent in error.** Major Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Raymond Grady, Administrator  
Methodist Hospitals Inc  
600 Grant St  
Gary, In 46402

Dear Administrator:

**The enclosed documents were NOT sent in error.** Methodist Hospitals Inc is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Nancy Bakewell, Administrator  
Monroe Hospital  
4011 S Monroe Medical Park Blvd  
Bloomington, In 47403

Dear Administrator:

**The enclosed documents were NOT sent in error.** Monroe Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Timothy Dicke, Administrator  
Orthoindy Hospital  
8400 Northwest Blvd  
Indianapolis, In 46278

Dear Administrator:

**The enclosed documents were NOT sent in error.** Orthoindy Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Haroon Naz, Administrator  
Pinnacle Hospital  
9301 Connecticut Dr  
Crown Point, In 46307

Dear Administrator:

**The enclosed documents were NOT sent in error.** Pinnacle Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/

Randall Snyder, PT., MBA  
Division Director  
Acute Care



2 North Meridian Street • Indianapolis, IN 46204  
317.233.1325  
[www.statehealth.in.gov](http://www.statehealth.in.gov)

To promote and provide  
essential public health services.



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Sean Dardeau, Administrator  
Porter Regional Hospital  
85 East Us Hwy 6  
Valparaiso, In 46383

Dear Administrator:

**The enclosed documents were NOT sent in error.** Porter Regional Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Seth Warren, Administrator  
Riverview Health  
395 Westfield Rd  
Noblesville, In 46060

Dear Administrator:

**The enclosed documents were NOT sent in error.** Riverview Health is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Warren Forgey, Administrator  
Schneck Medical Center  
411 W Tipton St  
Seymour, In 47274

Dear Administrator:

**The enclosed documents were NOT sent in error.** Schneck Medical Center is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Leo Correa, Administrator  
St Catherine Hospital Inc  
4321 Fir St  
East Chicago, In 46312

Dear Administrator:

**The enclosed documents were NOT sent in error.** St Catherine Hospital Inc is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Janice Ryba, Administrator  
St Mary Medical Center Inc  
1500 S Lake Park Ave  
Hobart, In 46342

Dear Administrator:

**The enclosed documents were NOT sent in error.** St Mary Medical Center Inc is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Gary Fammartino, Administrator  
St Vincent Carmel Hospital Inc  
13500 N Meridian St  
Carmel, In 46032

Dear Administrator:

**The enclosed documents were NOT sent in error.** St Vincent Carmel Hospital Inc is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Jerry Laue, Administrator  
St Vincent Dunn Hospital Inc  
1600 23rd St  
Bedford, In 47421

Dear Administrator:

**The enclosed documents were NOT sent in error.** St Vincent Dunn Hospital Inc is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Gary Fammartino, Administrator  
St Vincent Fishers Hospital Inc  
13861 Olio Road  
Fishers, In 46037

Dear Administrator:

**The enclosed documents were NOT sent in error.** St Vincent Fishers Hospital Inc is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Blake Dye, Administrator  
St Vincent Heart Center Of Indiana Llc  
10580 N Meridian St  
Indianapolis, In 46290

Dear Administrator:

**The enclosed documents were NOT sent in error.** St Vincent Heart Center Of Indiana LLC is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Joel Feldman, Administrator  
St Vincent Hospital & Health Services  
2001 W 86th St  
Indianapolis, In 46260

Dear Administrator:

**The enclosed documents were NOT sent in error.** St Vincent Hospital & Health Services is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care



Indiana State  
Department of Health  
*An Equal Opportunity Employer*

Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Sarah Knisely-King, Administrator  
St Vincent Neighborhood Hospital  
9613 East Us Highway 36  
Avon, In 46123

Dear Administrator:

**The enclosed documents were NOT sent in error.** St Vincent Neighborhood Hospital is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/

Randall Snyder, PT., MBA  
Division Director  
Acute Care



Eric J. Holcomb  
Governor

Kristina Box, MD, FACOG  
State Health Commissioner

July 9, 2018

Raymond Ingham, Administrator  
Witham Health Services  
2605 N Lebanon St  
Lebanon, In 46052

Dear Administrator:

**The enclosed documents were NOT sent in error.** Witham Health Services is receiving these documents as required by law pursuant to Indiana Code 16-34-2-4.5(d).

The statute does not prescribe what action must be taken by the facility regarding the documents. The facility may handle the documents in any manner deemed appropriate.

Respectfully,

/s/  
Randall Snyder, PT., MBA  
Division Director  
Acute Care